EXHIBIT 604.1

I N D E X

EXHIBITS

** [sic] Exactly as Stated

** (phonetic) As the Word Sounded

~*~

AMY RALSTON MCMASTER, M.D.
Forensic Medical Management Services
850 R.S. Gass Blvd.
Nashville, TN 37216
615-743-1800
amcmaster@forensicmed.com

EXPERIENCE

Forensic Medical Management Services
Chief Medical Officer, August 2010-present
Chief Operations Officer, July 2007-August 2010

Chief Medical Examiner, December 2010-present
Interim Chief Medical Examiner, March 2010-present
Deputy Chief Medical Examiner, July 2004-March 2010
Assistant Medical Examiner, July 2002- June 2004
Metropolitan Nashville/Davidson County

Deputy Tennessee State Medical Examiner
January 2010-present

Anatomic and Clinical Laboratory Associates
Baptist Hospital Department of Pathology
Nashville, TN
February 1999 to May 2001

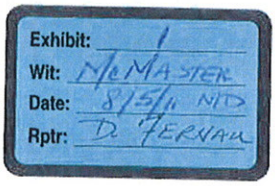
EDUCATION

Fellowship in Forensic Pathology
Miami/Dade County Medical Examiner Department
Miami, Florida
July 2001 to June 2002

Anatomic and Clinical Pathology Residency
Vanderbilt University Medical Center, Nashville, TN
Concentrated 5th year in Forensic Pathology at
Nashville/Davidson County Medical Examiner's Office
1996-2001

Doctor of Medicine
Meharry Medical College, Nashville, TN
May 1996

Bachelor of Science, Chemistry
Middle Tennessee State University, Murfreesboro, TN
May 1992



UNITED STATES DISTRICT COURT OF THE SOUTHERN DISTRICT OF WEST VIRGINIA CHARLESTON DIVISION

Kathy McCornack, et al.

Plaintiffs,

vs.

Actavis Totowa, LLC, et al.

Defendants.

THIS DOCUMENT RELATES TO:

Case No.: 2:09-cv-0671

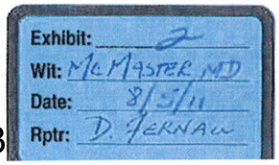
Related MDL Case No.: 2:08-md-1968

NOTICE TO TAKE VIDEOTAPED ORAL DEPOSITION AND REQUEST FOR PRODUCTION AND COPYING OF DOCUMENTS AT THE DEPOSITION

TO ALL PARTIES AND TO THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that, under Federal Rules of Civil Procedure 26(d), 30 and 45, Plaintiffs will take the deposition of **DR. AMY McMASTER** on **Friday, August 5, 2011 at 10:00 a.m.** at Vowell & Jennings, 214 2nd Ave. N., Suite 207. Nashville, TN 37201, (800) 256-1935.

The oral examination will continue from day to day until completed. This deposition will be recorded stenographically, may be recorded on videotape and will comply with any relevant orders in this litigation, including Pretrial Order No. 22, attached hereto as Exhibit A. This deposition is noticed in the above-captioned matter for any and all purposes permitted by the Federal Rules of Civil Procedure and any other federal, state, or local rules that apply to this action and the deposition will be taken in accordance with these rules. A copy of the subpoena duces tecum to appear and testify at a hearing or trial in a civil case is attached hereto as Exhibit



B and served herewith. Pursuant to Federal Rule of Civil Procedure 30(b)(2) and 45(a), Plaintiffs request that Dr. McMaster produce for inspection at the time of deposition:

1 The witness' current curriculum vitae or resume.

2 All correspondence and communication between the witness or anyone acting on the witness' behalf, and attorneys representing defendants in this and the MDL Digitek® litigation.

3 All other documents prepared by the attorneys for the defendants and sent to the witness.

4. All documents, including documents and deposition transcripts which refer or relate to this and the MDL Digitek® litigation that the witness received from any source.

5. All retainer agreements or other agreements under which the witness has been or will be paid for work related to this and the related MDL Digitek® litigation.

6. All bills that the witness has rendered to attorneys and law firms in connection with this and the MDL Digitek® litigation.

7. A copy of the witness' entire file, including all electronic documents, and correspondence, in connection with this and the MDL Digitek® litigation.

8. All documents, including additional materials received or reviewed, tangible things, data, or writings that relied upon, examined, considered, or rejected in preparing the reports in this and the MDL Digitek® litigation, or subsequent to preparing his report.

9. Everything the witness reviewed that indicates any person may have ingested defective Digitek®.

10. All notes that the witness has taken in connection with review of this and the MDL Digitek® litigation matters.

11 All documents that the witness has prepared concerning the subject matter of this and the MDL Digitek® litigation.

12. All medical, scientific or other literature on which the witness relies in connection with the opinions expressed in his expert report.

13. All documents, tangible things, data, or writings concerning whether a Digitek® tablet that may have been adulterated may have ever been received by a pharmacist or consumer. This request is not limited to just the Digitek® tablets recalled in 2008 by Defendant Actavis, but to all Digitek® tablets that may have ever been received by a pharmacist or consumer and suspected to be adulterated for any reason.

14. All documents the witness reviewed in preparation for this deposition.

Respectfully Submitted:

Dated: July 13, 2011

/s/ Terry Kilpatrick

Terry Kilpatrick (Calif. Bar No. 163197)
Attorneys for Plaintiffs
Ernst Law Group
1020 Palm Street
San Luis Obispo, CA. 93401
Tel: 805-541-0300
Fax: 805-541-5168
E-mail: tk@ernstlawgroup.com

CERTIFICATE OF SERVICE

I hereby certify that on July 13, 2011, I or an employee under my control electronically filed the foregoing document with the Clerk of Court using the CM/ECF system, which will send notification of such filing to all counsel of record.

Dated. July 13, 2011

/s/ Terry Kilpatrick

Terry Kilpatrick (Calif. Bar No. 163197)
Attorneys for Plaintiffs
Ernst Law Group
1020 Palm Street
San Luis Obispo, CA. 93401
Tel. 805-541-0300
Fax. 805-541-5168
E-mail: tk@ernstlawgroup.com

12-15 07 15 min letter review

12-16 09 1hr lit search

12-16 1hr record review

12-17 15 min phone call

Billed

7 microscopic sections

? ethanol use

TUCKER ELLIS & WEST LLP
ATTORNEYS AT LAW

1150 Huntington Bldg. 925 Euclid Avenue Cleveland, Ohio 44115-1414
phone 216.592.5000 facsimile 216.592.5009 tuckerellis.com

Direct Dial: 216.696.2276
Email: matthew.moriarty@tuckerellis.com

November 10, 2009

Exhibit: 3
Wit: McMASTER MD
Date: 3/5/11
Rptr: D. FERGUSON

4-26-11

5-12-11 2hrs

5-13 2hrs

5-14 3hrs

5-23-11 1½hrs review of Crb hrs revisions

8-3-11 30 min phone

Amy Ralston McMaster, M.D.
850 R.S. Gass Blvd.
Nashville, TN 37126

Re: *Kathy McCornack, an individual; Daniel E. McCornack, Jr., an individual; and Ralph J. McCornack, a minor by and through his mother and next friend Kathy McCornack v. Actavis Totowa, LLC, a New Jersey corporation, et al.*

Dear Dr. McMaster:

Thank you very much for agreeing to review this case. We represent Actavis Totowa, LLC, the manufacturer of Digitek®. Digitek® is a generic digoxin product, which is sold in two doses, .125 mg and .250 mg. In April 2008, the company recalled all lots of Digitek® that were on the market and within the expiration date. A small number of "double-thick" tablets were found during a pre-release inspection of one batch, and the recall was initiated out of an abundance of caution. I have enclosed the original recall notice as well as the FDA's latest statement about the subject. In the wake of the recall, lawsuits were filed alleging that out of specification Digitek® caused various medical problems.

This case is about Daniel McCornack, who died at the age of 45 just after midnight on March 23, 2008. He was diagnosed with early onset atrial fibrillation at approximately the age of 22 (1987). He was initially prescribed a digoxin product but apparently shortly thereafter stopped taking it and did not begin taking digoxin products again until December, 1994. Beginning in 1996 and until his death he was consistently prescribed .25 mg twice daily, for a total dose of .50 mg per day. Throughout the years Mr. McCornack consistently saw two doctors – Lawrence VonDollen, M.D. (cardiology) and Gordon Lemm, M.D. (primary care physician). Mr. McCornack had a variety of problems unrelated to his heart, such as gout and back pain. His other problems included obesity, multiple stressors, and hypercholesterolemia. While the records contain few references to hypertension, his primary care physician testified that Dan was hypertensive, and his cardiologist said that Diltiazem had secondary benefits in reducing Dan's blood pressure. To the best of our knowledge Mr. McCornack never had any instances of elevated serum digoxin concentrations, and there are no diagnoses of digoxin toxicity in his medical records.

On March 22, 2008, the family went on an Easter weekend camping trip. Mrs. McCornack said that Mr. McCornack exhibited no signs of illness before he went to bed that night. According to his wife, Mr. McCornack took his evening dose after dinner and went to bed at approximately 10:00 p.m. At approximately midnight he was making an unusual snoring

sound. When his wife tried to arose him, Mr. McCornack was not responsive. The family called 911 and efforts were made to revive him, but unfortunately Mr. McCornack passed away.

The coroner's office performed an autopsy and drew a post mortem blood sample (from the axillary vein) approximately 70 hours after Mr. McCornack died. They sent it to a laboratory called NMS. As you will see from their report, they found a blood digoxin concentration of 3.6, a diltiazem level of 630, and traces of quinidine (although he was not any pharmaceutical products containing that drug). NMS laboratory was also later called upon to analyze the "potency" of five or six of Mr. McCornack's Digitek® tablets. All of them were within the labeled specifications.

Initially the coroner prepared an autopsy report and a death certificate which attributed Mr. McCornack's death to natural causes, specifically listing cardiac arrest, ventricular arrhythmia, atrial fibrillation and hypertensive and arteriosclerotic cardiovascular disease. The day before his deposition, a year and a half after Mr. McCornack's death and 15 months after receiving the NMS report, the coroner changed his autopsy and death certificate to reflect an accidental death attributable to elevated digoxin levels. The coroner's new opinion is based wholly on the post mortem serum digoxin level of 3.6.

We have enclosed the following materials:

1 The office records of Dr. Lemm;

2. The office records of Dr. VonDollen (which include a consult from another cardiologist, Dr. Winkle);

3 The original autopsy and death certificate;

4. The "amended" autopsy and death certificate;

5 Reports from NMS Laboratories regarding Mr. McCornack's blood and Digitek® tablet tests;

6. The deposition transcript of the coroner, Dr. Mason;

7. The deposition of Matthew McMullin, Ph.D., a forensic toxicologist at NMS Laboratories, who comments on the blood and tablet test results; and

8. The deposition transcripts of Drs. Lemm and Von Dollen.

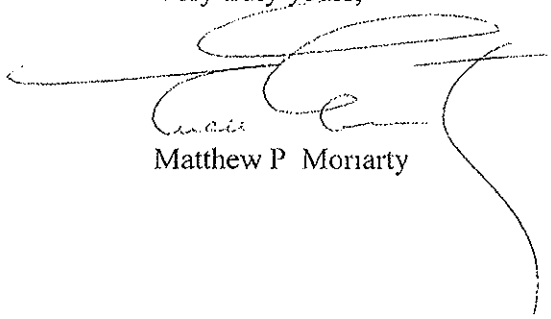
We are interested in your opinion regarding the reliability of this post mortem serum digoxin concentration of 3.6 as a predictor of Mr. McCornack's pre mortem levels. We are also

interested in your opinion about whether digoxin likely played a role in Mr. McCornack's death, and whether there is evidence that he got one or more excessive doses.

Further, as a Business Associate of Actavis Totowa, LLC, our Firm has agreed to maintain the confidentiality of protected health information (PHI) disclosed for the purpose of litigation. Because the enclosed records constitute PHI under HIPAA, you are required to treat such information as confidential and to use it only for the purpose of your expert review. If for any reason you are unable or unwilling to comply with these requirements, please notify me immediately and do not review the records.

Thank you very much for your time and consideration. We look forward to hearing from you.

Very truly yours,



Matthew P Moriarty

MPM:rcf
Enclosures

FORENSIC MEDICAL

May 17, 2011

Mr. Matthew Moriarty
Tucker Ellis & West, LLP
1150 Huntington Bldg.
925 Euclid Avenue
Cleveland, Ohio 44115

Re: McCornack v. Actavis Totowa, LLC

Dear Mr. Moriarty:

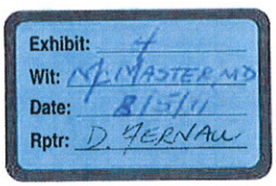
This letter serves as my expert medical opinions regarding the death of Mr. Daniel McCornack. I am currently the Chief Medical Examiner of Nashville/Davidson County in Nashville, Tennessee. I also serve as the Chief Medical Officer of Forensic Medical Management Services. I practice forensic pathology exclusively. I am board certified by the American Board of Pathology in anatomic, clinical, and forensic pathology. In addition to my primary medical examiner practice, I also provide expert medical opinions in forensic pathology as a consultative service. This consultative service consists of less than 10% of my professional practice. I hold medical licenses in Tennessee and Mississippi. I do not keep a list of cases in which I have provided expert medical opinions or testimony.

In forming my opinions in this matter, I have reviewed the following material: medical records from Dr. Gordon Lemm from 1994 through 2008; various laboratory reports from different sources dated 1994 through 2007; radiograph reports from various sources dated 1995 through 2005; pathology reports from skin and colon biopsies; undated electrocardiograms; medical records from Dr. Lawrence Von Dollen dated 1998 through 2007; additional laboratory reports dated 2002 through 2007; cardiology consultation from Dr. Roger Winkle; echocardiography reports dated 1995, 2001, and 2006; electrocardiograms dated 2000, 2001, 2004, 2006, and 2007; death certificate issued April 7, 2008; autopsy report; amended death certificate dated 9/30/2009; autopsy report (presumably amended) with revised cause of death, manner of death, and pathologic diagnoses; laboratory reports from NMS Labs dated June 24, 2008, May 29, 2009, and September 22, 2009; CVS Caremark recall letter; FDA statement of recall for Digitek® tablets; Santa Cruz County Sheriff-Coroner report; opinion of Keith Patrick Gibson, Pharm.D., J.D.; and depositions of Kathy McCornack, Dr. Von Dollen, Matthew McMullin, Dr. Gordon Lemm, and Dr. Richard Mason.

Mr. McCornack was a 45 year old white male found unresponsive by his wife near midnight on March 22, 2008 during a camping trip. Emergency medical personnel responded and Mr. McCornack was pronounced dead a short time later at 00:52 on March 23, 2008. He was apparently in his normal state of health and was not ill prior to being found unresponsive. His past medical history is significant for atrial fibrillation, hypertension, obesity, and hypercholesterolemia. An autopsy was performed by

Office of the Medical Examiner
850 R.S. Gass Blvd. • Nashville, TN 37216-2640
Phone: (615) 743-1800 • Fax: (615) 743-1890
www.forensicmed.com

Accredited by National Association of Medical Examiners



Dr. Richard Mason on March 26, 2008, approximately 79 hours after death. Blood was submitted to NMS Labs for toxicology testing. Dr. Mason certified the cause of death as ventricular arrhythmia due to atrial fibrillation due to hypertensive and atherosclerotic cardiovascular disease with exogenous obesity as a contributory cause. The manner of death was certified as natural. However, an undated amended autopsy report inexplicably changes the cause of death to ventricular arrhythmia due to digoxin toxicity due to digoxin poisoning. In addition, an amended death certificate dated September 30, 2009 also lists digoxin toxicity due to digoxin poisoning as the cause of death with hypertensive and atherosclerotic cardiovascular disease and exogenous obesity as contributory causes.

After review of all available information, it is my expert medical opinion that Mr. McCornack died of hypertensive and atherosclerotic cardiovascular disease with obesity as a contributory cause. There is no medical or scientific basis to support the diagnosis of digoxin toxicity or digoxin poisoning as causing, or in any way contributing to, Mr. McCornack's death. As documented in the autopsy report, Mr. McCornack has several cardiac findings capable of causing sudden cardiac death: enlarged heart (500 grams), left ventricular hypertrophy, coronary atherosclerosis, and myocardial fibrosis. The enlarged heart and thick left ventricle are due to long-standing hypertension. The myocardial fibrosis is indicative of previous myocardial ischemia or previous myocarditis. Any of these three conditions are well-documented causes of sudden cardiac death by causing a fatal arrhythmia, typically a ventricular arrhythmia. Obesity is a contributory cause of death. Additional autopsy findings include pulmonary congestion and edema and fatty liver. Pulmonary congestion and edema are non-specific findings. The fatty liver is most likely secondary to obesity; however, without microscopic sections, other etiologies cannot be completely excluded.

NMS toxicology report dated June 24, 2008 for postmortem blood of Mr. McCornack provides the following results: 0.048% blood ethanol, 630 ng/mL diltiazem, 3.6 ng/mL digoxin, trace quinine, and atropine. The ethanol in the blood may be due to antemortem alcohol ingestion, from postmortem in vivo production, or from a combination of both. Atropine is from attempted resuscitation. The source of the trace quinine is unknown. Diltiazem and digoxin were both prescribed for management of Mr. McCornack's cardiac conditions and are expected findings in the postmortem toxicology. As described below, the diltiazem and digoxin levels are non-toxic and would not contribute to death.

Due to postmortem redistribution, the levels of diltiazem and digoxin reported in the blood do not accurately reflect their levels in Mr. McCornack's blood when he was alive. Reliance on the postmortem digoxin level alone to determine the cause of death has no scientific or medical basis. Therefore, Dr. Mason's revised opinion that Mr. McCornack died of digoxin toxicity is erroneous and lacks scientific foundation. Postmortem redistribution describes the substantial changes that can occur in drug concentrations in the blood between death and when a postmortem blood sample is drawn (typically at autopsy). The process of postmortem redistribution is well recognized in forensic pathology and is abundantly documented in the forensic scientific literature. It generally refers to the diffusion of a drug across a concentration gradient in the body after death, but it also refers to the movement of drugs that are highly bound in specific types of tissue (such as digoxin in heart muscle) into other body compartments. Postmortem distribution can begin shortly after death and will continue as the postmortem interval increases. Redistribution, although diminished, will even occur in blood drawn from peripheral vessels. In fact, it has been determined that serum digoxin levels nearly always increase after death due to leaching from the muscle, with an average antemortem/postmortem ratio ranging from 1.42 for femoral vein blood specimens to 1 96 for heart blood specimens (Disposition of Toxic Drugs and Chemicals in Man, Eighth Edition, Baselt, 2008). Since the postmortem blood from Mr. McCornack was drawn from the axilla, there is a great potential for an increased axillary vein digoxin

level due to cardiac muscle leaching. Animal studies support the finding that "antemortem digoxin levels cannot be reliably inferred on the basis of high postmortem levels of the drug alone" (Ferner, RE. *British Journal of Pharmacology* 2008; 66:4, 430-443). Therefore, the 3.6 ng/ml of digoxin as reported by NMS in postmortem blood is not an accurate reflection of the antemortem digoxin level in Mr. McCornack, and the antemortem level was lower than the postmortem level. While some patients may manifest digoxin toxicity with "normal" levels of digoxin in the blood, the clinical diagnosis relies on signs and symptoms that, as discussed below, were simply not present in Mr. McCornack. In short, this postmortem digoxin level alone cannot be used as a basis for the diagnosis of digoxin toxicity.

The circumstances and investigative information surrounding someone's death must be taken into consideration with the autopsy findings and toxicology results when forming a final opinion regarding cause of death and manner of death. Not only is the digoxin level alone not high enough to cause toxicity and death, none of the symptoms typically reported with digoxin toxicity (nausea, vomiting, dizziness, blurred vision, decreased consciousness) were reported by Mr. McCornack just prior to his death. According to the Santa Cruz Sheriff-Coroner report Mr. McCornack was described as never being in any discomfort or pain that day. His wife said he did not complain of vomiting, vision changes, or any irregular heartbeats on the day of his death.

Finally, evaluation of digoxin pills submitted to NMS for examination shows that they are all of relatively uniform strength, weight, and thickness.

I also disagree with and find no medical basis for the final opinions expressed by Keith Patrick Gibson, Pharm.D., J.D. First, Mr. Gibson is simply not qualified, either in education or experience, to offer an expert medical opinion of cause of death. Second, his opinion that "Mr. McCornack had an elevated digoxin level at the time of his demise" is directly contradictory to other evidence and facts contained in Mr. Gibson's own report. And, third, Mr. Gibson's statement that "the elevated digoxin level was probably the result of a change in formulation of the Digitek tablet or a non-conforming tablet" is speculative, at best.

In summary, after review of all available information, in my expert medical opinion, Mr. McCornack's cause of death is hypertensive and atherosclerotic cardiovascular disease, with obesity as a contributory cause. The manner of death is natural. Digoxin toxicity did not contribute to or cause Mr. McCornack's death.

Sincerely,

Dr. Amy R. McMaster

KEITH PATRICK GIBSON

Attorney at Law / Pharmacist / Forensic Pharmaceutical Consultant
1241 Johnson Avenue, PMB #318
San Luis Obispo, CA 93401
Voice/Fax: (805) 980-4035
e-mail: keithpatrickgibson@gmail.com

EDUCATION

UNIVERSITY OF THE PACIFIC
*Top 40% of Class
McGeorge School of Law
JURIS DOCTOR — December 1985

UNIVERSITY OF SOUTHERN CALIFORNIA
Graduation Award: Obergfel Brothers Award
School of Pharmacy
DOCTOR OF PHARMACY — June 1980

PROFESSIONAL LICENSES

California Bar Number 127278
Passed: February 1986 Exam (First Attempt)
Admitted: December 1986

California Pharmacist #35695

United States District Court
Eastern District of California
Admitted: December 1986

EMPLOYMENT

Maguire & Ashbaugh
991 Osos Street, Suite A, San Luis Obispo California 93401
Position. **Deputy Public Defender**
July 1987 to Present
Worked under contract for the law firm of Maguire & Ashbaugh, who have the primary contract to perform the services of the Public Defender for the County of San Luis Obispo, California. While under contract, performed all the duties of a Deputy Public Defender with total responsibility for all cases at all phases from arraignment through trial and sentencing in the assigned Department of the Superior Court.

Office of Administrative Hearings
501 J Street, Suite 230, Sacramento, California 95814
Position: **Administrative Law Judge *pro tempore***
March 1995 to Present
Served under contract as a pro tempore Administrative Law Judge to preside over hearings for the Office of Administrative Hearings concerning the authorization for the involuntary administration of psychotropic medications by the California Department of Corrections & Rehabilitation (CDCR) to individuals confined within the jurisdiction of the CDCR. Conducted assigned proceedings and made all orders prior to, during and at the conclusion of the hearing.

Forensic Pharmaceutical Consultant
1241 Johnson Avenue #318, San Luis Obispo, California 93401
Position: **Consultant & Expert Witness**
August 1988 to Present
Provided information to lawyers about the pharmacology of both legal and illegal drugs. Provided information about the physiology of the human organism including the physiology of the kidney and liver as it relates to the detection and elimination of drugs. Conducted investigations, prepared reports and testified as an expert witness.

Private Practice
1108 Garden Street, Suite 205, San Luis Obispo, California 93401
Position: **Attorney**
December 1990 to November 1994
Past responsibilities with the Public Defender allowed for a non criminal law private practice that results in a total of about 5 to 10 hours of a work week spent on civil law matters. Handled cases involving workers' compensation, family law, debt collection, unlawful detainer and general business law issues.

Marian Medical Center
1400 Church Street, Santa Maria, California
Position: Clinical/Operational **Staff Pharmacist**
August 2005 to Present
Currently working as a clinical/operational staff pharmacist, responsible for all aspects of the pharmacy operation including clinical services, drug information, patient chart review, order entry, IV admixture and technician supervision.

Sutter Community Hospitals
52nd and F Streets, Sacramento, CA 95831
Position: **Staff Pharmacist**
July 1981 to July 1987
Staff pharmacist duties included the following: inpatient and outpatient orders, maintained patient profiles, IV admixture program, control of aseptic technique and admixture incompatibilities, unit does system, chemotherapy admixture program, quality control audits, technician supervision and information retrieval for medical staff. Developed Aseptic Technique Course and manual. Wrote orientation manual and orientation procedures for new employees.

ORGANIZATIONS

San Luis Obispo County Bar Association
American Civil Liberties Unions (ACLU)

President, Cuesta Society of Hospital Pharmacists (1991)
American Association for the Advancement of Science (AAAS)
California Attorneys for Criminal Justice (CACJ)

CLAIM TO FAME: Football: Honorable mention, All League (1973 - College of the Sequoias), attended University of Hawaii on sports scholarship (1974).

(Rev. 2011-01)

EXHIBIT
5

KEITH PATRICK GIBSON, PHARM.D., J.D.

Forensic Pharmaceutical Consultant

Post Office Address
1241 Johnson Avenue, PMB #318
San Luis Obispo, California 93401

California State Bar Number 127278
California Register Pharmacist License Number 35695

e-Mail: keithpatrick@gibson.org
Voice / Fax: 805-980-4035

May 16, 2011

Don A. Ernst
Ernst Law Group
Attorneys at Law
1020 Palm Street
San Luis Obispo CA 93401

Re: McCornack vs. Actavis Totowa, LLC

Dear Mr. Ernst:

At your request I am providing my opinion on the post-mortem drug levels found in Mr. McCornack's blood, the distribution of digoxin and other drugs post-mortem, the effect of differing formulations of digoxin on bioavailability and the resulting clinical picture that is the likely cause of Mr. McCornack's death.

Daniel E. McCornack was a 45 year old Caucasian male who died on March 23, 2008 at approximately 0030. At the time of his death, he was 70 inches tall, approximately 220 pounds.[1] The Sheriff-Coroner's report from Santa Cruz County listed cardiac arrest as the cause of death.[2]

The records indicate that the deceased was taking the following medications:[3]

Drug	*Sig*	*Directions*
Diltiazem CD 360mg.	1 po qAM	One tablet every morning
Diltiazem CD 180mg:	1 po qPM	One tablet every evening
Digitek 0.25mg:	1 po bid	One tablet two times a day
Allopurinol 100mg:	3 po qDAY	Three tablets every day
Aspirin 325mg:	1 po qDAY	One tablet every day
Prevacid 30mg:	1 po qDAY	One tablet every day
Indocin	Prn	As needed

[1] Report Report of Autopsy Examination by Richard T. Mason, M.D., Forensic Pathologist
[2] Sheriff-Coroner, Santa Cruz County, Death Investigation Report and Supplemental Report, Case Number 08-02797, by N. Silva
[3] Refill Tracking Form: attached to the Deposition of Richard T. Mason, M.D., dated 10-01-2009

KEITH PATRICK GIBSON, PHARM.D., J.D.
Forensic Pharmaceutical Consultant

Post Office Address
1241 Johnson Avenue, PMB #318
San Luis Obispo, California 93401

California State Bar Number 127278
California Register Pharmacist License Number 35695

e-Mail: keithpatrickgibson@gmail.com
Voice/Fax: 805-980-4035

Rates for Professional Services

- Preparation .....$250/hr.
  - Review of reports
  - Literature research for medical or forensic topics
  - Medical chart evaluation
- Court testimony or deposition..... $400/hr. (4 hrs minimum)
- Travel time .....$125/hr.
- Minimum charge for any travel outside county..... ..... $2000/day
- Costs for travel and housing are billed as received.
- Costs for production of professional articles are billed as received.

Should any questions arise or to make arrangements, please contact me at the email or other address above.

Sincerely.

Keith Patrick Gibson, Pharm.D., J.D.

(effective 1-1-2011)
KPG/dbm

Kathy McCornack reports that her husband took his medication after breakfast and immediately after dinner every day. On the day of his death, Mrs. McCormack did not see her husband take his daily meds, however, she did have a conversation with one or both of her sons about Mr. McCornack's drug usage. The sons reported that their father consumed his medications immediately after the evening meal.

In her deposition, Mrs. McCornack describes the evening meal occurring in the late afternoon/early evening before sundown, or that the preparation for the evening meal began at that time. It seems the evidence then is that the deceased consumed his medications around 6 to 8 p.m and suffered a cardiac arrest at 30 minutes past midnight that same evening.

The following are the last ante mortem lab results for Mr. McCornack:[4]

Date	*Time*	*Digoxin*	*S Creat*	*Bun*
05-15-2007	0808	1.6	1.2	8.0

Post-mortem drug levels were obtained for alcohol, diltiazem, digoxin, quinidine /quinine and atropine.[5] Those levels were obtained from a peripheral site and the results are summarized below:

Drug	*Post-mortem Level*
Ethyl Alcohol	48 mg/dL (BAC = 0.48 % w/v)
Diltiazem	630 ng/mL
Digoxin	3.6 ng/mL
Qunidine/Quinine	Trace
Atropine	Positive

Mr. McCornack was prescribed digoxin to treat his heart condition.[6] Digoxin is a drug used to treat congestive heart failure and certain irregular contractions of the heart call arrhythmias. Digoxin can increase the force of myocardial contractions (positive inotropic effect) or can be used to treat irregular contractions of the heart known as arrhythmias such as atrial fibrillation, atrial flutter or ventricular tachycardia.[7]

The mechanism of action of the drug involves the increase in the influx of calcium ions from the extracellular to the intracellular cytoplasm of the cell. It does this by inhibition of the transport of sodium and potassium ion movement across the myocardial membrane. This increase in calcium ions results in a potentiation of the contractile force of the heart muscle fibers (positive inotropic effect). The drug also may inhibit adenosine triphosphatase (ATPase) and decrease conduction through the S-A and AV nodes.[8]

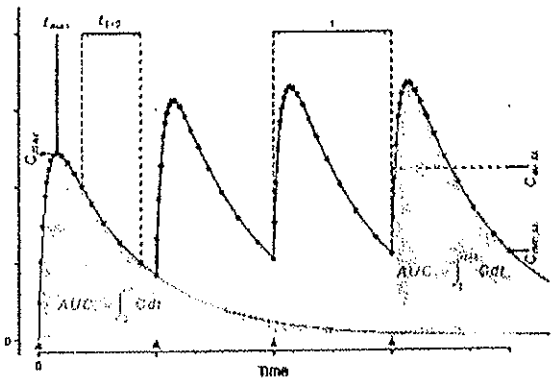
[4] Central Coast Clinical Lab, Templeton CA dated 05-15-2007
[5] Supplemental Toxicology Report of: McCornack, Daniel E., NMS Labs, dated 06-24-2011
[6] Deposition of Gordon Lemm, M.D., 10-02-2009; Deposition of Lawrence Von Dollen, M.D. 10-05-2009.
[7] Leikin & Palouchek's, *Poisoning & Toxicology Handbook*, 3rd Edition (2002), Pg 484
[8] Leikin & Palouchek's, *Poisoning & Toxicology Handbook*, 3rd Edition (2002), Pg 484

The distribution of the digoxin is minimal to body fat; high concentrations to myocardium, skeletal muscles and kidney; and it crosses the blood brain barrier. The volume of distribution in adults is 7 L/Kg (decreased with renal disease). The half-life in adults is approximately 39 ± 13 hours.[9]

Therapeutic digoxin levels are reported to be from 0.8 to 2 ng/mL.[10] Concentrations of digoxin above 0.8 ng/mL are associated with an inotropic effect.[11]

Toxicity is an important clinical problem. The therapeutic and toxic effects of digoxin are dose-related. The drug has a narrow therapeutic index. The therapeutic index is a comparison of the amount of a therapeutic agent that causes a therapeutic effect to the amount that causes toxicity or death.[12] Casually stated, therapeutic index is the difference between the therapeutic dose and the toxic dose.

Plotting the blood concentrations vs. time for a hypothetical drug is demonstrated by this graph. Where the blue line with the blue dots represents the blood level over multiple doses.



Note the maximum level for the first dose is lower than the steady state peak level. The peaks and troughs for a drug will be consistent at steady state. Steady state is defined as that time in which the intake of drug equals the excretion of the drug. 90% of steady state will be achieved at approximately 4 times the half-life.[13]

When a new dose is introduced or the bioavailability is changed, the next peak after the change will be higher or lower depending on whether bioavailability increases or decreases. Thus a peak after a new larger dose will be higher than the proceeding peak and the peaks and troughs will be consistent once steady state is reached.

---

[9] Gilman et al, *Goodman and Gilman's The Pharmacological Basis of Therapeutics*, 8th Edition, 1990; Pg 1675

[10] Ellenhorn M. and Barceloux D., *Medical Toxicology, Diagnosis and Treatment of Human Poisoning*, 1988, Elsevier; Pg 204

[11] Goodman & Gilman's The Pharmacological Basis of Therapeutics, 11th Edition , 2006

[12] *Katzung and Trevor's Pharmacology Examination & Board Review, 9th Edition*, McGraw Hill; Pg 15

[13] Evans W.E., Schentag J.J., Jusko W.J., *Applied Pharmacokinetics: Principles of Therapeutic Drug Monitoring* (1980); Pg 342

Digoxin is available in two strengths as a tablet: 0.125mg and 0.25mg.[14] Bioavailability is the extent to which a drug becomes available to the target tissue after administration.[15] Gastrointestinal (GI) absorption of digoxin is normally approximately 60 to 85%.[16 17] It can be as high as 100% with some formulations.

The onset of action from an oral dose is 1-2 hours with a peak effect occurring at 4-8 hours.[18] Goodman and Gilman describe the maximal effect being apparent 4 to 6 hours after administration.[19]

Tablet formulation can have a significant effect on absorption and hence bioavailability. Tablet ingredients include materials to hold the tablet together and to break up the tablet when consumed. Tablet ingredients can include the following:

- Drug – in this case digoxin
- Lubricant – to facilitate the tablet pressing process
- Granulating agent - tends to stick the ingredients together
- Filler – to give the tablet a size that is easy to handle
- Wetting agent - helps the penetration of water into the tablet
- Disintegration agent - helps to break the tablet apart

Inappropriate combinations of the above can result in tablets that are (1) too hard and do not break apart when consumed which results in a decrease in absorption; or (2) not hard enough and break apart too easily, increasing the exposed surface area and increasing absorption of the drug.

Niazi spoke about the effect of particle size on absorption of digoxin.[20] One study quoted by Niazi, reports that by decreasing particle size from 102*u* to between 7 and 13*u*, absorption increased to approximately 100%.[21]

The calculations, shown below, performed by Globalrph,[22] use the steady state information from Mr. McCornack quoted above. Changes in steady state levels will increase with increased bioavailability.

% Increase in Bioavailability	*Dose*	*Steady State Level*
0	0.50	1.60
10	0.55	1.76
20	0.60	1.92
30	0.65	2.08
40	0.70	2.24
50	0.75	2.40

[14] Drug Facts and Comparisons 2011, Wolter Kluwer Publisher
[15] Dorland's Illustrated Medical Dictionary, 27th Edition, Pg 206
[16] The Merck Manual, 16 Edition, 1992; Pg 456
[17] Leikin & Palouchek's, *Poisoning & Toxicology Handbook*, 3rd Edition (2002), Pg 485
[18] The Merck Manual, 16 Edition, 1992; Pg 456
[19] Gilman et al, *Goodman and Gilman's The Pharmacological Basis of Therapeutics*, 8th Edition, 1990; Pg 828
[20] Niazi S., *Textbook of Biopharmaceuticals and Clinical Pharmacokinetics*, (1979); Pg 29
[21] Journela et al, Effect of Particle Size on the Bioavailability of Digoxin (1975); *J Clin Pharmacol* 8:365
[22] http://www.globalrph.com/digoxinss.cgi

Life threatening arrhythmias are the most important toxic effect of digoxin.[23] Clinical manifestations of digoxin toxicity include all forms of cardiac arrhythmia including ventricular premature depolarizations, junctional tachycardia and AV block among others.[24] The probability of digoxin-induced arrhythmias is as follows:[25]

Digoxin Concentration	*% probability of digoxin-induced arrhythmias*
1.7 ng/mL	10%
2.5 ng/mL	50%
3.3 ng/mL	90%

Non-cardiac symptoms of toxicity include gastrointestinal and neurophyschiatric symptoms (nausea, vomiting, diarrhea, agitation, lethargy, and visual disturbances).

The factors influencing the "likelihood of toxicity" were described in Goodman and Gilman.[26] These factors include the following:

1. incorrect selection of a maintenance dose,
2. use of a diuretic that decreases potassium,
3. patient ingesting an incorrect number of tablets,
4. increased absorption due to intestinal changes associated with antibiotic usage,
5. decrease in renal function,
6. electrolyte abnormalities
    a. depletion of potassium,
    b. abnormally high calcium levels, or
    c. abnormally low magnesium levels,
7. hypothyroidism (decreasing digoxin elimination),
8. other pharmacological agents,
9. advanced age, or
10. change in the formulation of the drug resulting in increased bioavailability,
    a. the result of an unknown change in formulation by the manufacturer, or
    b. caused by the substitution of one brand for another with different formulations

Diltiazem is a calcium channel blocking agent with the following characteristics:

- Distribution: V_d: 3-13 L/kg
- Protein binding: 70% to 80%
- Bioavailability: Oral: ~40% (undergoes extensive first-pass metabolism)

[23] The Merck Manual, 16 Edition, 1992; Pg 455
[24] *Manual of Medical Therapeutics, 26th Edition*, Department of Medicine, University of Washington School of Medicine (1989)
[25] Goodman & Gilman's The Pharmacological Basis of Therapeutics, 11th Edition , 2006
[26] Gilman et al, *Goodman and Gilman's The Pharmacological Basis of Therapeutics*, 8th Edition, 1990; Pg 834

- Half-life elimination: Immediate release tablet: 3-4.5 hours, may be prolonged with renal impairment; Extended release tablet: 6-9 hours; Extended release capsules: 5-10 hours; I.V.. single dose: ~3.4 hours; continuous infusion: 4-5 hours
- Time to peak, serum: Immediate release tablet: 2-4 hours; Extended release tablet: 11-18 hours; Extended release capsule: 10-14 hours
- Excretion: Urine (2% to 4% as unchanged drug; 6% to 7% as metabolites); feces Absorption: Immediate release tablet: >90%; Extended release capsule: ~93%
- Maximum dose is 540mg/day.[27] [28]

Diltiazem does exhibit post-mortem redistribution.[29] Calcium channel blockers have been associated with an increase in digoxin levels. [30] The American Association of Poison Control Centers practice guidelines do not list a toxic diltiazem blood level.[31]

The question of whether we can determine the level of digoxin in the blood at the time of death arises in this case. Hair analysis has not shown a correlation between blood digoxin and digoxin in hair that can be useful.[32]

Certain changes occur in the drug concentrations found in the deceased human. As the body dies, active processes that distribute a drug up a concentration gradient cease, cells die sometimes releasing their contents into the extracellular space and into the blood.[33] Diffusion can occur at all levels in the body resulting in redistribution.

Post-mortem redistribution (PMR) refers to one subset of those changes.[34] It involves the redistribution of drugs into the blood from solid organs such as the liver, lungs or, as in this case, the myocardium. The properties of a drug that one should consider when assessing the extent of PMR is the drug's volume of distribution, lipophilicity, and pKa.

Basic, highly lipophilic drugs with a volume of distribution greater than 3 L/Kg were identified by Yarema and Becher as candidates for PMR. Digoxin was identified by these authors as a candidate for PMR.[35] Some authors maintain that very high *in vivo* volumes of distribution with high concentrations in specific tissues have been proposed as a

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[27] Lexicomp Online, rev. April 2011
[28] Olson et al, Calcium Channel Bloker Ingestion: An Evidence-Based Consensus Guideline for Out-of-Hospital Management, *Clinical Toxicology* (2005); 43:797-822
[29] Moriva F., Hashimoto Y., Redistribution of diltiazem in the early post-mortem period, *J Anal Toxicol* (2004); 28(4): 269-71
[30] Cardiac Glycosides/Calcium Channel Blockers (Nondihydropyridine), Lexicomp Online Interaction Monograph, April 2011
[31] Olson et al, Calcium Channel Bloker Ingestion: An Evidence-Based Consensus Guideline for Out-of-Hospital Management, *Clinical Toxicology* (2005); 43:797-822
[32] Deveaux et al, Immunoassay of digoxin in hair, *J Forensic Sci* 1997; 84: 219-223
[33] Yarema M.C. and Becker C.E., Key concepts in post-mortem drug redistribution, *Clin Toxicol (Phila)* 2005; 43(4): 236
[34] Koren G. and MacLeod S.M., Post-mortem redistribution in digoxin in rats, *J Forensic Sci*, 1985; 30(1): 92-6
[35] Yarema M.C. and Becker C.E., Key concepts in post-mortem drug redistribution, *Clin Toxicol (Phila)* 2005; 43(4): 235

marker for PMR.[36] [37] [38] Ferner points out that the density of the body is approximately 1 kg/L, so that if a drug is uniformly distributed in a person weighing 70kg (the standard man), the volume of distribution will be 70L. This suggests that the volume of distribution used to determine if PMR will be present should be a volume of distribution of approximately 70L.[39]

Post-mortem redistribution (PMR) will result in a drug moving from sites of high concentration to sites of lower concentration. Ferner states:

> "Where the distribution is non-uniform before death, the possibility arises after death that the distribution will become more uniform simply because there will be flow down any concentration gradient from high concentration to lower concentration. Organs in which drug is concentrated are loci of high concentrations, and concentrations in surrounding tissue can be disproportionately affected. The concentration measured in blood, in these circumstances, depends strongly on the sampling site. For example, digoxin is preferentially distributed to cardiac muscle, after death, concentrations in heart blood are substantially higher than those in femoral venous blood, presumably because of redistribution from cardiac muscle into heart blood."[40] [41]

Digoxin is preferentially distributed to cardiac muscle. At steady state, the concentration of digoxin in the cardiac tissue is 15 to 30 times those of the plasma. The concentration in the skeletal muscle is about half that in the heart.[42]

Digoxin may exhibit a passive redistribution after death.[43] It has been suggested that the 'ideal site' to obtain blood is a ligated or clamped femoral vein.[44] Peripheral blood is less likely to have an altered digoxin level due to its distance from solid organs such as the liver, lungs or the myocardium. The femoral vein is a large vein in the groin and upper thigh. It is the primary route for the return of blood to the heart from the lower extremities. In general, redistribution into peripheral vessels, such as the femoral vein, is less than redistribution into central vessels.[45]

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[36] Pounder DJ, Jones GR, Post-mortem drug redistribution — A Toxicological Nightmare, *Forensic Sci Int* 1990; 45: 253-63

[37] Leikin J, Watson W, Post-mortem toxicology: What the Dead can and cannot tell us. *J Toxicol Clin Toxicol* 2003; 41: 47-56

[38] Hilberg et al, The extent of post-mortem drug redistribution in a rat model. *J Forensic Sci* 1999; 44: 956-62

[39] Ferner R.E., Post-mortem clinical pharmacology, *Br J of Clin Pharmacol* (2008); 66(4): 435

[40] Ferner R.E., Post-mortem clinical pharmacology, *Br J of Clin Pharmacol* (2008); 66(4): 430

[41] Holt D.W. and Benstead J.D., Post-mortem assay of digoxin by radioimmunoassay, *J Clin Pathol* (1975); 28: 483

[42] Gilman et al, *Goodman and Gilman's The Pharmacological Basis of Therapeutics*, 8th Edition, 1990, Pg 828

[43] Pelissier-Alicot et al, Mechanisms underlying post-mortem redistribution of drugs: a review, *J. of Analytical Toxicology*, 27(8): 533

[44] Yarema M.C. and Becker C.E., Key concepts in post-mortem drug redistribution, *Clin Toxicol (Phila)* 2005; 43(4): 235

[45] Cook DS, Braithwaite RA, Hale KA; Estimating ante mortem drug concentrations from post-mortem blood samples: the influence of post-mortem redistribution, *J Clin Pathol* (2000); 53:282-285

There is considerable discussion about the findings of Vorpahl and Coe in the literature.[46] The purpose of their study was to determine a way to estimate the digoxin level ante mortem from post-mortem levels. They proposed a post-mortem to ante mortem ratio of 1.96 for heart vein samples, 1.63 for subclavian vein samples, and 1.42 for femoral vein samples. Using this ratio, Mr. McCornack's post-mortem level of 3.6 ng/mL would equate to an ante mortem level of 2.5 ng/mL.

Location	*Ante/Post Ration*	*Extrapolated Blood Level*
Heart Vein	1.96	1.8
Subclavian Vein	1.63	2.2
Femoral Vein	1.42	2.5

Koren and MacLeod showed with a post-mortem analysis of rats that when the digoxin concentration is in the therapeutic or low toxic range, digoxin may re-enter the blood stream after death by passive redistribution. However, high ante-mortem digoxin concentrations "may prevent such passive redistribution." Their conclusion was that: "Therefore, ante mortem digoxin intoxication cannot be reliably inferred on the basis of high post-mortem levels of the drug." The authors continued to state that "Digoxin intoxication can be ruled out when post-mortem SDC (serum digoxin concentration) remain within the therapeutic range."[47]

When interpreting post-mortem drug levels, post-mortem drug redistribution needs to be considered.[48] Post-mortem drug levels do reveal some facts and it has been said that the integration of ante mortem history with post mortem drug concentrations can be used to glean some facts about the deceased.[49] Laboratory data obtained after death considered in light of the pre-death laboratory data correlated with the patients' clinical condition at the time of death is necessary to render an appropriate opinion on the cause of death.[50]

Based on the "likelihood of toxicity" factors described by Goodman and Gillman and the information described above, I have made the following analysis:

Mr. McCornack was not on an antibiotic and did not report any intestinal changes other than a vague bloated feeling. He was not on a potassium sparing diuretic. There is no evidence of hypothyroidism, an electrolyte abnormality or decreased renal function. And he was not of an advanced age.

Mr. McCornack had been on this drug regimen for years. At his last check up, he exhibited no signs or symptoms leading his physicians to change this drug regimen. At his last full workup by his physician, the patient had a digoxin level obtained at steady state that was appropriate for his diagnosis.

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[46] Vorpahl T.E. and Coe J.L., Correlation of ante mortem and post-mortem digoxin levels, J Forensic Sci (1978); 23(2): 329-34

[47] Koren G. and MacLeod S.M., Post-mortem redistribution in digoxin in rats, *J Forensic Sci*, 1985; 30(1): 92-6

[48] Shepherd M.F., Lake K.D. and Kamps M.A., Post-mortem changes and pharmacokinetics: Review of the Literature and Case Report, *The Annals of Pharmacotherapy*, 1992; 26(4): 510-14

[49] Kennedy MC, Post-mortem Drug Concentrations, *Intern Med J* (2010); 40(3): 183-7

[50] Yarema M.C. and Becker C.E., Key concepts in post-mortem drug redistribution, *Clin Toxicol (Phila)* 2005; 43(4): 235

Mr. McCornack was taking one 0.25mg tablet two times a day. The level obtained on May 15, 2007, from Mr. McCornack was from a blood sample obtained just before his next dose. Normally, analysis is done with peak levels obtained 4 to 8 hours (preferably at 6 hours) after administration. Mr. McCornack's level, on the other hand, was taken at a time that reflects his lowest drug level over the course of a day.

I have considered other causes for his digoxin to be elevated, including his use of diltiazem. Considering that the patient had been on this drug regimen for some time with no ill effects, nothing points to diltiazem as the causal agent on this particular night.

The last factors to consider are an incorrect administration of the evening dose or an abnormality in the tablet ingested.

It my understanding that Mr. McCornack was using a daily tablet dispenser. Mr. McCornack distributed his tablets into the dispenser for each day's dose. The possibility that Mr. McCornack would have consumed an incorrect number of tablets is highly unlikely because of this fact.

It should be noted that Mr. McCornack suffered a cardiac arrest at the time the digoxin blood level was reaching its maximum peak. We know from Mr. McCornack's post-mortem drug levels that he had a large amount of digoxin stored in his body (peripheral digoxin blood level was 3.6 ng/mL). Considering that the deceased had been stable on his medications at their current doses for some time, something was different the night he died. In my opinion, Mr. McCornack's digoxin blood level was reaching its maximum at the time of his demise and this was a primary factor in his death.

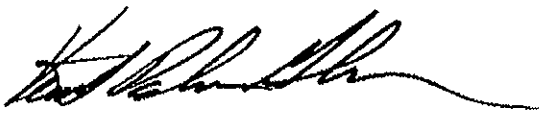
In the year prior to his death, Mr. McCornack was asymptomatic as to the effects of digoxin poisoning. If Mr. McCornack did have a high or elevated digoxin level for reasons other than a tablet abnormality, he was asymptomatic by all accounts that I could review.

Therefore, it my opinion that:

- Mr. McCornack had an elevated digoxin level at the time of his demise,
- The elevated digoxin level was probably the result of a change in the formulation of the Digitek tablet or a non-conforming tablet, and
- Judging from Mr. McCornack's clinical conditions on the night of March 23, 2008, digoxin poisoning was the cause of his death.

I appreciate the opportunity to work on this interesting fact pattern.

Sincerely.



Keith Patrick Gibson, Pharm.D., J.D.

KPG/dbm

Other References:

1. Jusko WJ, et al. Pharmacokinetic design of digoxin dosage regimens in relation to renal function. J *Clin Pharmacol* 1974;14:525-35.

2. Koup JR, et al. Digoxin pharmacokinetics: role of renal failure in dosage regimen design. *Clin Pharmacol Ther* 1975;18:9-21.

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9. Bigger JT. The quinidine-digoxin interaction. *Mod Con Card Dis* 1982;51:73-78.

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11 Reuning RH, Garaets DR. "Digoxin", in Evans W, Schentag J, Jusko J (eds): *Applied Pharmacokinetics*. Applied Therapeutics, Inc, San Francisco 1986; pp 908-43.

12. Pounder D. and Jones G., "Post-mortem drug redistribution — A Toxicological Nightmare", *Forensic Science International*, 1990; 45(3): 253

Compliance with Rule 26

A. Statement of Opinion

a. See report above.

B. Facts or Data Considered

a. See attached report and list of references
b. Deposition of Kathy McCormack, 10-05-2009, and Exhibits
c. Deposition of Lawrence Von Dollen, M.D., 10-05-2009, and Exhibits
d. Deposition of Richard T. Mason, M.D., 10-01-2009, and Exhibits
e. Deposition of Gordon Lemm, M.D., 10-02-2009, and Exhibits
f. Expert Report of David M. Bliesner
g. Expert Report of Dr. Walter Kernan dated July 1, 2010

C. Exhibits

- None

D. Witness Qualifications

- **Professional License:**
  - California Pharmacist License Number 35695
- **Education**
  - Doctor of Pharmacy, University of Southern California, School of Pharmacy (1980)
- **Work Experience**
  - See attached resumes.

E. List of Publications Authored in the Previous 10 years

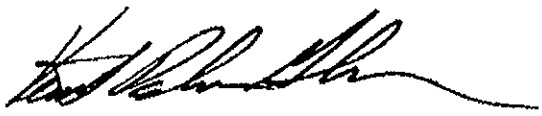
- None

F. List of Cases in Which Expert Testified or was Deposed in the last 4 years

- None

G. Statement of Compensation. See attached Billing Rate Sheet.

Dated: May 16, 2011



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Keith Patrick Gibson, Pharm.D., J.D.
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San Luis Obispo, California 93401
Home Phone: (805) 542-9245
California License Number 35695

Education

1980 – **Doctor of Pharmacy**, University of Southern California, School of Pharmacy

1985 – Juris Doctor, University of the Pacific, McGeorge School of Law

Experience

2005 – Present Clinical Pharmacist, **Marian Medical Center**, Santa Maria

Currently working as a clinical staff pharmacist, responsible for all aspects of the pharmacy operation including clinical services, drug information, patient chart review and drug distribution.

2004 – 2005 Staff Pharmacist, **Community Health Centers** of the Central Coast, San Luis Obispo Pharmacy

Worked the out-patient pharmacy, participated in the services provided to the Mental Health In-Patient Unit which includes the delivery of unit dose, Pryxis, QA (quality assurance), DUR (drug utilization review), policy and procedure development and on-call pharmacist services.

1992 – 2004 Staff Pharmacist, **San Luis Obispo County Hospital**

Worked in the in-patient and out-patient pharmacies. Participated in the daily dispensing of drugs. Duties included dispensing as well as those usually assigned to a clinical pharmacist. Participated in QA (quality assurance) and DUE (drug utilization review).

1990 – 1992 Staff Pharmacist, **Marian Medical Center**

1987 – 1990 Staff Pharmacist, **Twin Cities Community Hospital**

Worked in the in-patient pharmacy and participated in pharmacist controlled drug protocols.

1981 – 1987 Staff Pharmacist, **Sutter Community Hospital**

Staff pharmacist duties included the following: in-patient and out-patient orders, maintained patient profiles, IV admixture program (with Harvard infusion pumps), control of aseptic technique and admixture incompatibilities, unit does system, chemotherapy admixture program, quality control audits, inventory control, prepackaging program, technician supervision and information retrieval for medical staff. Developed an Aseptic Technique Course and manual. Wrote the orientation manual and orientation procedures for new employees.

References

Cliff Elliott, former Director of Pharmacy, San Luis Obispo County General Hospital
Additional references available upon request

RECORDTRAK
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RT #:196975 Tag: 1

DANIEL E. MCCORNACK, SR

CASE: DANIEL E. MCCORNACK, SR VS.
ACTAVIS TOTOWA, ET AL
COURT DOCKET: MDL 1968 /
SSN ###-##-7837 D.O.B.: 02/15/1963 D O.D : 03/23/2008
PLAINTIFF COUNSELERNST AND MADISON

LOCATION: DR. GORDON LEMM

IN RESPONSE TO RECORDTRAK'S REQUEST FOR THE FOLLOWING:
1. ALL MEDICAL RECORDS IN YOUR POSSESSION. INCLUDE OFFICE QUESTIONNAIRES/HISTORY & RECORDS RECEIVED BY OTHERNCE, PHYSICIANS PLEASE ALSO INCLUDE THE PATIENTS INFORMATION SHEET. PLEASE BE SURE TO INCLUDE ALL ARCHIVED RECORDS AND ALL RECORDS LOCATED IN STORAGE.

MEDICAL RECORDS ARE ATTACHED.

DGT.CG01

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651 Allendale Road
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Phone: (800) 220-1291
Fax: (610) 354-8946

196975.1

August 7, 2009

Re: DANIEL E. MCCORNACK, SR

MEDICAL RECORDS
DR. GORDON LEMM
292 POSADA LANE
SUITE D
TEMPLETON CA 93465

SS #: ###-##-7837
DOB: 02/15/1963 DOD: 03/23/2008
RT FILE #: 196975 TAG #: 1

Dear Record Custodian:

Attached is an authorization requiring you to furnish *RECORDTRAK* with the following materials on or before August 7, 2009:

1. ALL MEDICAL RECORDS IN YOUR POSSESSION. INCLUDE OFFICE AND HAND WRITTEN NOTES, TEST RESULTS, CORRESPONDENCE, QUESTIONNAIRES/HISTORY & RECORDS RECEIVED BY OTHER PHYSICIANS. PLEASE ALSO INCLUDE THE PATIENTS INFORMATION SHEET.PLEASE BE SURE TO INCLUDE ALL ARCHIVED RECORDS AND ALL RECORDS LOCATED IN STORAGE.2. SIGNED CERTIFICATION PAGE IS REQUIRED.

Please fax responses along with our request and certifications to RecordTrak at the fax number listed above. If the records are too voluminous to fax, please provide them on CD or mail paper copies to the address listed above.

Before copying and/or invoicing, call or fax *RECORDTRAK* with a page count and pricing for approval. Please include your federal tax id number on all invoices. Refer to File # 196975 Tag 1 in any correspondence.

Very Truly Yours,

RecordTrak Representative
Phone: (800) 220-1291

IMPORTANT:
*****RESPONSES WILL NOT BE ACCEPTED WITHOUT COMPLETED AND SIGNED CERTIFICATION(S).*****

DEMGL:0006

08/13/2009 23:25 7146326791 EZ COPY PAGE 02

DGT.CG01

DEPONENT: DR. GORDON LEMM (TAG 1)
RECORDS PERTAIN TO: DANIEL E. MCCORNACK, SR
RECORDTRAK FILE #: 196975 DATE OF BIRTH: 02/15/1963 SOCIAL SECURITY #: ###-##-7837
RECORD IDENTITY:

196975.1

1. ALL MEDICAL RECORDS IN YOUR POSSESSION. INCLUDE OFFICE AND HAND WRITTEN NOTES, TEST RESULTS, CORRESPONDENCE, QUESTIONNAIRES/HISTORY & RECORDS RECEIVED BY OTHER PHYSICIANS. PLEASE ALSO INCLUDE THE PATIENTS INFORMATION SHEET.PLEASE BE SURE TO INCLUDE ALL ARCHIVED RECORDS AND ALL RECORDS LOCATED IN STORAGE.2. SIGNED CERTIFICATION PAGE IS REQUIRED.

SECTION I CERTIFICATION OF CUSTODIAN OF RECORDS

I, the undersigned, being the duly authorized custodian of records or other qualified witness, and having the authority to certify the attached records declare the following: the attached records (1) were made at or near the time of the act, event, condition, opinion or diagnosis by a person with knowledge of the matters reflected in the records; (2) were kept in the course of regularly conducted activity; and (3) were created as part of the regular practice of the provider, and that:

A – X page(s) of the original records described was made available to the attorney's representative for copying at our place of business.
B – a true, legible and durable copy of _____ pages of the described records was delivered to the attorney's representative.

I DECLARE, UNDER PENALTY OF PERJURY, THAT THE FOREGOING IS TRUE AND CORRECT.

Executed on (date) 8/18/09 at (city,state) Templeton CA

Signature Arleen Buzzelli Print Name Arleen Buzzelli

Phone Number (805) 434-3211 Department Medical Records

E-mail Address to Forward Requests for Production of Records/Materials: _____

SECTION II CERTIFICATION OF NO RECORDS

A thorough search of our files, carried out under my direction revealed no documents, records or other materials called for in the subpoena or authorization, for the following reason:

☐ All records for the time period in question have been destroyed in accordance with our document retention policy which is ___ years.

☐ Our records are the same as _____

☐ Original records are in the possession of _____

☐ (other) _____

I DECLARE, UNDER PENALTY OF PERJURY, THAT THE FOREGOING IS TRUE AND CORRECT.

Executed on (date) _____ at (city,state) _____

Signature _____ Print Name _____

Phone Number _____ Department _____

E-mail Address to Forward Requests for Production of Records/Materials: _____

THIS PAGE MUST BE COMPLETED, SIGNED AND RETURNED.

RECORDS

DEMGL:0007

McCormack, Daniel

Date 8.17.94 M.P.

BP 140/80 P 72 R 16

T ___ wt 201 ht. ___

Allergies Ampicillan
Sulfa

Meds. Tenormin prn
½ bid pm

S: 31yo ♂ c/o fatigue x 6 mths, now with headaches x 2 wks, occas sorethroat x 2 wks
Generally healthy but has atrial arrhythmia dx by Harvey, then Von Dollen. Takes Tenormin when heart races only.
Stressful job - never vacations - Works his job + 400 acre ranch

O: HEENT - WNL
Cor - reg irregularity
lungs - clear
thyroid ok
Abd benign
Ext - WNL
Neuro intact

A Fatigue
Atrial arrhythmia

P Chem + 20/Thyroid
Old records
May need cxr - GL

8:23-94 lab results WNL. Chol a little high. Rec

DEMGL:0046

McCernack, Dan

Date 3-11-96 CC: mole & freckle check
132/70 72 16
T 103
Sulfa
ampicillin
Lanoxin .25mg IV qd
Dilacor 180 AM
Dilacor 120 pm
Cordarone

Pt has noticed many recent moles on his trunk which have appeared probably over recent months. Very difficult to pinpoint duration. No family hx of problems.

O: Many nevi on trunk
Many very dark, but regular
No bleeding.
Shave biopsy done of black lesion @ back - 2 mm (.5cc 1% Xylo + epi)

A Multiple nevi - biopsy / lesion
P Call pt. [signature]

3-16-96 Biopsy - dysplastic nevus - Pt has many of these, Needs to see dermatologist - wife called.

3-18-96 Pt has an appt. for today w/ Dr. Stanton. J [signature]

Date 12.9.96 CC: eyes swollen, red, irritated, started yesterday morning. worse in the A.M.s
BP 114/70 P 76 R 16
T ___ wt. ___ ht. ___
Allergies Sulfa
ampicillin
Meds. Lanoxin .25mg IV qd
Dilacor 180 mg AM.
Dilacor 120 mg P.M.

Maybe related to setting up Christmas tree?
No crusting.
O: Mod swelling periorbital
+2 Scleral injection + swelling.
Ø exudate

A Allergic Conjunctivitis
P Ocular + gtt OU gtt pm
Benadryl + g D #7 given [signature]

DEMGL:0045

McCornack, Dan

Date 4.2.98
BP 120/80 P 80 R ____
T ____ wt 212 ht. ____
Allergies Sulfa
Ampicillan
Meds Lanoxin .25 mg bid
Dilacor 180 mg AM
120 mg pm

CC: ① ✓ nail of big toe (L) foot nail turning colors.
② pain & aching (L) shoulder difficulty sleeping.
Great toenail fungus x 3 mths.

XRAY
(L) shoulder

(L) shoulder separation and deltoid tear 18yrs ago - no surgery done.
Now chronic pain - sometimes keeps him awake. Painful rotation, extension + lifting in posterior aspect.

D: Onychomycosis toenail ⑤ great toe
(L) shoulder. painful internal rotation - positively abduction OK.
XRAY done

A2

Date 2-2-99
BP 120/80 P ____ R ____
T ____ wt 222 ht. ____
Allergies Ampicillin
Sulfa
See list

CC: poss. sinus inf - pressure in head, headaches sinus congestion ears plugged. coughing up green phlegm in AM. No temp. X 9 days.

Dan F Mccormack CHN[illegible]
SOS ACCT 077489-00 COPAY 0.00
Blue Cross Prudent R 595[illegible]
OFF F DOB 02/15/63 GNDR M
Dan F Mccormack
6255 Peachy Canyon Rd
Paso Robles, CA 93446
PH 805-238-5208
2/02/99 02 1:40PM APPT [illegible]
F Reply N Gordon Lemm M D

P Caffein 250 bid #20
Flonase
38799

DEMGL:0044

CHART NOTE

PATIENT: MCCORNACK, DAN
MMA NO: 95-53-22-3
DATE: 02/02/99

SUBJECTIVE: Patient has been fighting a sinus infection for the last three weeks with head pressure, headaches, teeth hurt, ears are plugged. He is now coughing up green phlegm in the morning time. This has been acutely worse in the last nine days. He is allergic to ampicillin and Sulfa.

OBJECTIVE: Moderately congested. TMs are slightly dull. Nasal mucosa is swollen, erythematous. Pharynx mild erythema. Adenopathy none. Heart regular rate without murmurs. Lung sounds reveal occasional wheeze.

ASSESSMENT:
Sinusitis and mild bronchitis.

PLAN:
Ceftin 250 mg bid, #20. Flonase sample given 2 sprays each nostril once or twice a day.

GORDON LEMM, M.D.

GL:YOG/05516449/dm D: 02/02/99 T: 02/03/99 JOB#: 38799

DEMGL:0043

Date 2-5-99

BP ___ P ___ R ___

T ___ wt. ___ ht. ___

Allergies ___

Meds ___

Dan F Mccornack CH9553223
303 ACCT 072489-00 COPAY 15 00
Blue Cross Prudent B 555917837
OFF f DOB 02/15/63 GNDR mal
Dan F Mccornack
6255 Peachy Canyon Rd
Paso Robles, CA 93446
PH 805-238-5208
02/05/99 08 45AM APPT TYPE ov
L f P g1f N. Gordon Lamm M D

(S)

Date 4-2-99 c.c.
BP 148/80 (L) P ___ R ___ (1) Sx x 6 days started c
T 99.9 wt. 205 ht. ___ sore swollen throat,
Allergies Ampicillin headache, plugged ears, pressure
Sulfa in ears, cough, sneezing
Meds Lanoxin .25 Bid (2) awoke today c (L) eye matted.
Dilacor 180am 180pm (3) frequent lesions in back
36 year old of throat - white patches
come & go

[illegible]

DEMGL:0042

McCormack, Dan

Date _____
BP _____ P _____ R _____
T _____ Wt _____ Ht _____
Allergies _____
_____
Meds _____
_____

5-7-01 - FTKA. Val Thomas
5-7-01 - Rescheduled for next week. Val Thomas

Date 5.14.01
(L) BP 130/84 P 63 R 18 384/100 T C.C. pt here to reestablish
T _____ Wt 212 Ht _____ as a new pt. Pt has been seeing
Allergies Sulfa Dr. VonDollen and she needs a
Ampicillin referral for an echocardiogram
Meds Lanoxin .25mg bid holter
Dilacor 180mg q am and a 24hr Monitor. Dorina RR
120mg q pm Well otherwise.

Long hx of A. Fib probably 10-15yr ago -
recurrent problem - worse x 8yr ago.
See recent report from VonDollen -
intermittent A. Fib.

O. Con Ekg - 60's
Lungs clear
Edema 0

A A. Fib

P Echo/ 24 Hr Holter
Health/lipid panel RTC for Rx
EZ

DEMGL:0041

McCormack, Dan

(2) Date 6-14-01
BP 122/78 P ____ R ____
T ____ Wt 210 Ht ____
Allergies Sulfa
Amoxicillin
Meds Lanoxin .25mg/d
Dilacor 180mg 8am
120 mg 8pm

384/100 → Pt here for an annual physical. Had his labwork done. Felatried a ~~[illegible]~~ clot. Pt does have Atrial Fib. and he sees Dr. VonDollen regularly. XR
- Recent Echo pending.
- (R) foot pain on lateral forefoot intermittently x months. Worse c driving once. No back pain - May have muscle cramp at times.
- Saw Dr VonDollen in Feb for recent arm pain - worried about TIA; BP also up. Probably stress related.
- Herpes (oral) multiple times.

O: TRIG 263 HDL 44.7 LDL 115
Chol 212
HEENT - WNL
Cor RRRG 70-80
Lungs - clear
Abd obt - umbilical hernia
Genit obt
Ext - obt

A: 1. AFib/occas neuropathy (R) foot
2. Herpes Simplex / umbilical hernia
3. Hyperlipidemia

P: 1. Zovirax 400 BID x5d prn
2. Low fat diet

DEMGL:0040

McCormack, Dan

Date 7-26-01
BP 128/76 84 reg R
T ___ Wt 212 Ht ___
Allergies Sulpha
Ampicillin
Meds Celecox 300mg q AM
" 100mg q PM
Lanoxin .25 q BID

CC: R foot pain intermittent x 1 year, then on Sunday (7-22) started having pain L great toe into foot, & swelling or redness — mdn

See last visit
Intermittent pain in feet. Severe aching in L great toe Monday.
Pain has been in both feet intermittently for the past year, mostly in forefoot
Hx L great toe fx
Hx lumbar back problems c "pinched nerve in past. No recent problem Recent labor

O: Exam normal
No sensory motor loss
Mod pain c great toe ROM - perhaps slight erythema

A: Neuropathy in feet
Hx lumbar disc problems

P: HbA1c
Biz
RA, ANA, ESR, CRP, Uric Acid
RPR
XRAY L foot & lumbar spine
Neuro eval

DEMGL:0039

McCornack, Dan

8-31-01 Pt called requesting lab results - Explained that uric acid was high. Pt would like to know if it could be related to foot/leg pain & if so if there is an Rx. (Rite Aid Spring wk 239-1550) — mda

9-4-01 Uric acid level 10.4 - See letter from Dr Watson - Symptoms now consistent with arthritis although not characteristic for gout.

9-14-01 spoke c pt & explained above to him & read letter (portion) from Dr Yamagata to pt. He would still like to discuss c Dr. Lemm - set appt for 9/24 — M McAdam RMA

DEMGL:0038

McCormack, Dan

(L)
Date 9.20.01
BP 120/82 P ____ R ____
T ____ Wt 211 Ht ____
Allergies Sulfa
Amoxicillin
Meds Lanoxin .25mg qd
Diltiazem 120mg q AM
120mg q PM

38y/o ♂ cc Pt here for a sl'u on his (L) foot. Pt has been having pain off and on for a year and a half. Pt was in on 7/26 and had major pain until labor day weekend. Pt did see Dr. Yamagata but got no real answers. Pt had labs done. Pt wonders if it is gout —

See report from Dr Yamagata.
Labor day weekend had alot of pain in (L) foot
First flare of foot pain April - severe pain in (R) foot. Total 5 times in last 18 months. Three episodes lasted 4-5 days. Two episodes severe.

O = Foot exam normal presently
Uric Acid 10.2

A: Gout c multiple attacks in past 18 mths

P: Allopurinol 100mg #60 1qD
Indocin 50mg tid pc #30
CMP/U.A + appt 6wk
Low purine diet — GL

DEMGL:0037

McCormack, Dan

Date 10-23-01
(2) BP 132/82 P ___ R ___
T 98° Wt 211 Ht ___
Allergies Sulfa
Ampicillin
Meds Lanoxin .25mg qd
Dilacor 180mg q am
120mg q pm
Allopurinol 100mg qd
Indocin prn

38 y/o ♂ c.c. pt here for a cold in his chest x 2 ½ - 3 wks. Coughing productive c green mucus. Tight chest no other real symptoms. Has had headache & plugged ears. AR

Symptoms started in chest - continue c productive cough.

O: Nasal congestion
TM's dull
pharynx +2 erythema
Cor - RR&m
lungs - coarse BS

A Bronchitis

P ZPAK — [signature]

11-5-01 - Rite Aid - Lanoxin 250mcg #30 i bid. RFx PRN GL/AR
Spring Fay

11-5-01 - Written Rx - Lanoxin 250mcg #120 i bid RFx 0 GL/AR
pt will pickup

11-19-01 - Rite Aid - Allopurinol 100mg #30 i qd RFx 5 GL/Abelman
Spring Fay

11-21-01 See labs: Uric Acid 7.3
LFT SGPT 103
SGOT 36 — [signature]

DEMGL:0036

McCormack, Dan

Date 1-7-01
(L) BP 112/82 P ___ R ___
T ___ Wt 176 Ht ___
Allergies Sulfa
Ampicillin
Meds Lanoxin .25mg bid
Dilacor 180mg q am
120mg 8pm
allopurinol 100mg qd
Indocin prn

384/100 → C.C. pt had a real bad case of gout on a week ago Thurs. Lasted 2 wks, it is almost gone now. AR

Severe (R) foot pain while camping - Took Indocin c some relief. Drinks mod. beer. Generally watches diet. Very frustrated over recent attack.

O - Mild erythema dorsum (R) foot no cellulitis.

U.A 7.7
CMP ok

A: Gout   Diet reviewed
P: ↑ allopurinol 100 2 qD
U.A. CMP & appt 6 wks
↑ fluids

1-24-02 - Rite Aid - Spring fax   allopurinol 100mg #60 ii qd RFx3 ©/ARodman RMA

DEMGL:0035

McCormack, Dan

Date 2-19-02
BP 134/92 P R
T Wt 220 Ht
Allergies Sulfa
Ampacillin
Meds Lanoxin .25mg bid
Dilacor 180mg q AM
120 mg q pm
Allopurinol 100mg ½ qd

39 y/o ♂ C.C. pt here for f/u on his gout, pt has been doing better on the increased dose.
- (R) mg finger started a gout - only lasted 24hr.
- In general improving.
- See labs - Uric Acid 7.3
LFTs ok SGPT 76 (no change)

A: Gout - improving

P: Allopurinol 100mg ½ qD #120
Cmp, Uric acid
in 3 mth

Date 5-20-02
BP 132/90 P R
T Wt 220 Ht
Allergies Sulfa
Ampacillin
Meds Lanoxin .25mg bid
Dilacor 180mg q AM
300 mg / 180mg q pm
Allopurinol 100mg ½ qd

39 y/o ♂ C.C pt here for 3 month f/u, had recent labs done also. Has had no major gout attacks since last visit -
Pt quit chewing 5wks ago -
Minor pain in feet + occas hands.
Uric acid 7.4

A: Gout stable
P: Cont current Allopurinol
LABS 2 mths
Cmp UA

? 5-02 - Express Pharm - Diltazem 300mg #90 1 qAM RF x 3 BC/AR
fax - (800) 323-0161 Diltazem 180mg #90 1 qpm
see copy

DEMGL:0034

— McCormack, Dan —

Date 7-17-02
BP ____ P ____ R ____
T ____ Wt ____ Ht ____
Allergies Sulfa
Amp acillin
Meds Dilt-azem 300mg qam
Dilt-azem 180mg qpm
Lanoxin .25mg qd
Allopurinol 100mg tid

39 y/o ♂ c.c. Pt injured his (L) middle finger last night and jammed it into a bag of softball. Pt thinks its the joint. Has hx of trouble w/ gout right now.

O: Mild, mod tenderness (L) 3rd finger PIP joint. Slight swelling

Pt returns with xrays - no fracture

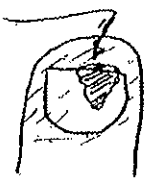
A: PIP sprain

P: Buddy tape prn

Date 7-29-02
BP 140/72 P ____ R ____
T ____ Wt ____ Ht ____
Allergies Sulfa
Amp acillin
Meds Dilt-azem 300mg qam
Dilt-azem 180mg qpm
Lanoxin .25mg qd
Allopurinol 100mg tid

39 y/o ♂ c.c. Pt here for a poss gout problem or an infected (R) big toe. Pt not sure. Started on Sat. Pt cut toenails short a few days ago

O: Mod erythema + tenderness of toe
Small margin of possible abscess
I+D - mod amount of pus drained. Now feeling better



A: Subungual abscess / Cellulitis

P: Keflex 500 #40 qid
Soak bid
Remove toenail if abscess returns

DEMGL:0033

— McCormack, Dan —

Date 8-20-02
BP 116/82 P ____ R ____
T ____ Wt ____ Ht ____
Allergies Sulfa
Ampicillin
Meds Diltiazem 300mg qhs
Diltiazem 180 ÷ qpm
Lanoxin 0.25 ÷ BID
Allopurinol 100 ÷ 1 qd

39 yo ♂ CC: follow up labs Re: gout. No problems c gout since first of year ——— Md
Has liberalized diet c problems.
Toe infection cleared up
finger sprain still bothersome somewhat
O: Cr 1.6
uric acid 7.9 (10.2 highest level)
SGPT 62
Mod swelling (L) 3rd finger PIP
A: Gout / finger sprain / Mild ↑ Cr
P: 3 mths - Dig level, Uric Acid, CMP

(L)
Date 11-2002
BP 128/80 P ____ R ____
T ____ Wt 223 Ht ____
Allergies Sulfa
Ampicillin
Meds Diltiazem 300mg qhs
Diltiazem 180mg ÷ qpm
Lanoxin 0.25mg ÷ bid
allopurinol 100mg ÷ qd

39 y/o ♂ C C. pt here for a 3 month f/u and lab results. Pt needs new Rx's for all his meds, for MR
Rx's for all his meds, to be mail away
- (L) foot swelling started 3 days ago but better today
- a few minor episodes of gout
- Hrs not been on diet
- (L) 3rd finger slowly healing. Still has painful grip
O: UA 8.2 Cr 1.4 Dig 1.5
No gout presently
Mod swelling + painful flexion PIP 3rd (L) finger s/p dislocation Mid July
A: Gout / Hx AFib
P: Zyloprim 300mg qD #90
Lipids/CMP/HHH/uric acid 3 mth
Rx Diltiazem 300 #60
" 180 #60 } RF6 — see copy, MR
Lanoxin .25 #120

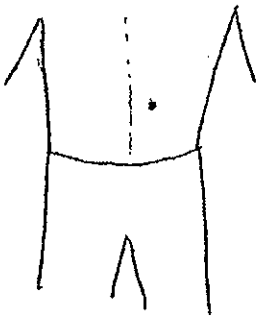
DEMGL:0032

McConnack, Dan

Date 2-19-03
BP 140/90 P 82 R
T Wt 225 Ht
Allergies Sulfa
Amoxicillin
Meds Diltiazem 300mg qam
Diltiazem 120mg q pm
Lanoxin 0.25mg qd
Allopurinol 100mg 1½ qd

40 y/o ♂ c.c. pt here for a 3 month f/u on his labs. Has not had any gout attacks, but has had fatigue. Pt has had some chest pain off and on, not severe. Feels it constantly when laying down on center of his chest. Poss skin check for pre-ca cheek. Pt has had indigestion problems also, worse at night. Burning in chest - esp at night.

- Gout has been quiet
- Occas epigastric pain - some relief w Maalox
- Hx atrial dysrhythmia
- Hx of abnormal nevus - biopsy was done by Dr Stanton.



O: Con-resp lungs clear Abd benign
EKG - PAC's See labs
2-3mm very dark nevus @ lumbar region - Shave biopsy today - 2cc 1% Xyl/0 c epi
Polysporin dressing

A: GERD/Gout/C.P. - not cardiac/PAC's
Nevus - type?

P: CMP/Lipids/UA 6 mth
Zantac 300 qpm #30 RF x2
Call if continued symptoms

2/21/03 R.A. Springst Acyclovir 400mg qid #120 Herpes - mod

DEMGL:0031

– McCormack, Dan –

Date 3-26-03
BP 142/84 P ____ R ____
T ____ Wt ____ Ht ____
Allergies Sulfa
Amphicillin
Meds Diltiazem 300mg qam
Diltiazem 180mg qpm
Lanoxin 0.25mg bid
Allopurinol 100mg qd
Zantac 300mg qpm

(L) 40y/o O'C.C. Pt here to have a lesion rev, we bx it in Feb. Pt also has pain in the center of his lower back. Pt says the muscles at times tighten up, pt says it feels like the vertebra are rubbing together This has been off and on for 2-3 wks. AR

O: Mod lumbar spasm + limited flexion
No radiculitis.
Neuro intact
Back – multiple nevi
Area of dysplastic nevus shave bx is clear no visible residual nevus

A Lumbar spasm / Dysplastic nevus

P: Exercises given
Skin check August

5/28. Pt's wife called Pt needs Rx faxed to RiteAid - Spring St/PR for following meds. Diltiazem 300mg. Lanoxin 0.25mg. Also needs refill slips for Diltiazem & Dilacor 180mg. Meds needed for 1 wk due to #238-5208
Other meds coming from mail away. TX, Fran
* done see flow sheet – AR

DEMGL:0030

McCormack, Dan

Date 8-19-03
BP 122/72 P ____ R ____
T ____ Wt 208 Ht ____
Allergies Sulfa
Ampicillin
Meds ~~Diltiazem 300mg QAM~~
Diltiazem 180mg QPM
Lanoxin 0.25mg bid
~~Allopurinol 100mg 1 tab~~
Zantac 300mg QPM
allopurinol 300 QD
ASA 325mg QD

40yo ♂ C.C. pt here for a 5 month check up and lab results. Pt thinks that he needs his eyes checked, was hunting and couldn't not tell if he was looking at a buck or doe.
- Has lost 15-18 lbs on Atkins diet.
- Maybe having problems after vision - may have hand retinal problem from Cordarone
- Zantac quite helpful
- no recent gout attacks

O: Cor-freq irreg - Rate 80
Lungs clear
Uric Acid 7.0
CMP ok
cholesterol better

A: Gout/Hyperchol

P: Allopurinol 300 QD #60 > RF 6
Zantac 300 QD #60
Lipids uric acid 6 mth

11/25/03 pt wife called - Pt would like refill on Lanoxin & Diltiazem 300mg & Diltiazem 180 mg Precision Rx. Cathy 238-5208 ext 25. Thanks
Faxed to Precision Rx - see copy OK

1x 4. Pt called Lanoxin will not arrive in time from mailaway. Please fax Rx for 10 day Supply to RA, Spring St. Tran. # 239-1777.

DEMGL:0029

- McCornack, Dan -

12/4/03 - Rite Aid - Lanoxin .25mg #30 + bid GC/AR Rodman Pmoz
Spring Fax

12/4/03 Patient notified by ARodmanRMA

1-15-04 Rite Aide called to say ins have changed and pt. needs new scripts to mail away:
Cartia - XT 300 mgs #90 90 x 3 please
Diltiazem 180 mgs #90 call to pick up Doug
Lanoxin .25 #180 at 928-5208
Allopurinol 300 mgs #90
Ranitidine 300 mgs #90
Rx's written as above GC/AR

1/28/04 - Caremark - Clarification & Dx for above Rx's GC/AR
fax See copy

1/30 Pt's wife called Requests Rx for Allopurinol x 7 days to cover while mailaway meds are shipped. A to CB re which pharmacy they want to use from.
R/A on Spring St

2-2-04 - Rite Aid - Allopurinol 300mg #20 Tel GC/AR
Springfax

DEMGL:0028

— McConnell, Dan —

Date 2-11-04
BP 172/82 P R
T Wt 201 Ht
Allergies Sulfa
Impacillin
Meds
See med list

40y/o → c.c. pt here for concerns about his Atrial Fib, pt has been dealing with a lot more stress at his job lately. Pt had some (L) testicular pain for 2 days last WK, and then started on Wed, he started having trouble c his stomach. SR

Rev BP 148/80

↑ work stress. Also more rapid recently -
Previously discussed Coumadin c Dr VanDella
"Ulcer pain" x 2 days - epigastric burning now better. Severe (L) scrotal pain intermittently x 3 days - not tender - LLQ "squeezing" pain
Tightness in neck at times
Dr Anxious ABSENT - ok
Cor-Irreg irreg clear Abd benign
3m Genitalia

A: Atrial fib - chronic / HTN
Gastritis
(L) ureteral stone ?
Stress

P: ABD CT renal stone protocol
CMP, Lipids, Dig level, T4, TSH,
Uric acid, H+H, Urine Analysis
Protonix 40mg QD #21
DC Zantac
RTC 2wks — GZ

CT 2-16-04, order faxed to T.I. dr

2-18-04 Discussed CT scan c pt
Please add CXR to order since he has "full" sensation in his neck — GZ

441-4257

DEMGL:0027

— McCornack, Dan —

Date 12-26-04
BP 124/82 P R
T Wt Ht
Allergies Sulfa
Ampacillin
Meds
Protonix 40mg qd
See med list

4/ylo ♀ c.c. pt here for a 2wk flu and test results. Pt has been nervous about his test results, still has stiffness in his neck & tingling at times. Has had some discomfort around his side.

O: Abd CT shows multiple small nodes 1 1/3 cm max size
Discussed possible etiologies. Pt has been tired & stressed lately - No fever.
Mild lower abd discomfort
Exam - No adenopathy
HEENT ok
Cor - RRR
Lungs clear

A: Fatigue - normal labs

P: Repeat abd/pelvic CT in 2 mths

3/1/04. Pt called. Only has 2 Protonix left. Can he please have more samples, plus, mail away Rx. #239-1550. Fran

Rx Protonix 40mg #90 RF 3 Samples #4

3/1/04 Patient notified by ARodmanRMA
Kathy will pick up tomorrow

DEMGL:0026

McCornack, Dan

Date 4-1-04
BP 142/70 P R
T Wt Ht
Allergies Sulfa / Septra
Ampacillin
Meds See Med List

4/1/04 c.c. pt here for a flu. Pt is still not feeling well, has been having good and bad days since his last visit. Pt says the pain starts in his lower abdomen like in the intestines.

Pt continues c suprapubic pain that radiates into scrotum - both sides - much worse after BM c severe cramping. No diarrhea, constipation. Initial symptoms around 2/8/04. Felt better for a little while now worse again. ABD CT showed multiple small lymph nodes - should repeat this month

O - Ca - RRSM
lungs clear
Abd - mild suprapubic tenderness
Rectal - normal Heme neg

A: Low grade prostatitis ?
Colon spasm
Lymphadenopathy on CT

P: Cipro 500mg #2820
CBC, CRP, ESR, PSA
Repeat abd/pelvic CT 2-3wk

Name Dan McCornack
Doctor Lum MD
Date 4/1/04
Collected by
voided / cath
yellow / bloody
straw / amber
clear / cloudy
hazy
Urobilinogen. WNL
Glucose. neg
Ketones. neg
Bilirubin. +
Albumin/Protein. + +
Nitrite. neg
Leukocytes. +
Blood. neg
PH. 5.0
Specific Gravity. 1.020
Microscopic:
RBC, WBC, Casts, Mucus
Epithelial, Bacteria, Other
Comments
occas WBC
1 cast ?
DiaScreen Urinalysis

4/1/04 - Sample of Cipro XR 1000mg given to pt to take one a day x 10 days - pt Rx in med Rm

DEMGL:0025

McCormack, Dan

Date 4-26-04
BP 132/80 P R
T Wt Ht
Allergies Sulfa; Septra
Ampicillin
Meds See med list

Hy to ↗ C.C pt here for a flu, pt had the lower abdominal pain that radiates into the groin on Thurs, Friday and Sat last wk. Pt states that he thinks there is something connected to his BM's. Pt still has the tightness in his throat, is concerned that he chewed tobacco for the last 20-30 years. Pt saw Dr. VonDollen last wk and had a good ck checked. AK

Felt much better p Cipro. Had some recurrence of pain in suprapubic area + groin. Pt reports stools as chalk

O. ABD CT - minor adenopathy unchanged pharynx ok no masses or Abd soft

A: Lower Abd pain / Appendectomy

P: BE
GI referral — Gy

4-29-04 pt. phoned req to Dr Lovich but he doesn't take his insurance. He would like another ref to GI. Ref pt. to Dr. Colbert for abd pain. ks

5-3-04 Notes faxed to Dr Fulbeck per pt's request. Pt will try to get sooner appt. ab

C.C. GI's not contracted w CCN. ab

DEMGL:0024

— McCormack, Dan —

5/10/04- Spoke c pt. re. B.E results. Pt was wondering if you stillwanted him to see the gastro. Has an appt 6/17, but he hasn't had any lower abdominal pain in 2wks. Also wanted to know when you wanted to see him next. Akelmanrnpa
- He may cancel c GI if feeling fine
- Follow up here in August

5/10/04 Patient notified by Akelman RNPA
Mom

1/1/04 - Caremark - Protonix 40mg #90 1qd No changes 6/4/04
fax
fax'ed to Case management

DEMGL:0023

McCornack, Dan

Date 8-22-04
BP 147/84 P R
T Wt 206 Ht
Allergies Sulfa; Septra
Amoxicillin
Meds See med list

41 y/o ♂ c.c. pt here for a flu from April. Pt is still having lower abdominal pain that radiates up into his neck. Is real concerned about the lymph node problem. Is wondering if this is a combo of the stress & diverticulitis that is causing the abdominal pain, AR

Intermittently feels terrible c myalgias, fatigue, lower abd pains. Occas tingling in hands. Long term back + neck problems. Pfizer has gout. Work strenuous

O: HEENT-WNL
Lgs - RRRM
Lungs clear
Abd ↓ masses
Adenopathy ↓

A: Fatigue, Myalgias, Gout, Adenopathy

P Repeat Abd CT
CMP, Lipids, Biz, CK, Uric Acid, TSH,
ESR H+H ANA CRP RA HLAB27
Consider MRI neck + lumbar
RTC 2 wk

DEMGL:0022

McCornack, Dan

Date 8-16-04
BP 124/94 P ____ R ____
T ____ Wt ____ Ht ____
Allergies Sulfa, Septra, Ampacillin
Meds See med List

6 4/y/o c.c. pt here for a 2wk flu and test results. Pt was feeling better and then friday he had the lower abdominal pain, but it only lasted a couple of hours and then was gone. Now has DD and on pain at times. PAR

Pain sometimes in genitals, perineum.
Ø Dysuria. Continues c intermittent fatigue

O: ⊕ HLA B27 neg ANA
Pt's Abd CT is unchanged c obesity
Nodes

A: Fatigue, back pain, genital pain
Neck pain - Reiter's? Ankylosing Spondylitis?
⊕ HLA B27 / Gout

P: Refer to Dr Eibschutz
XRAY C/L spine

8-16-04 Faxed records & labs to Eibschutz. CK

8-26-04 pc from pt's wife requesting ref to Rheumatologist in Palo Alto since pt can be seen earlier, to Dr. Genovese in Palo Alto
done ICK fax #650-725-8418. ck
(ok)

9.14.04 last years Med Recs copied - pt to pick up for appt w/ Rheumatologist. Thanks

DEMGL:0021

— McCormack, Dan —

10/11/04 - Written Rx - Diltiazem 300mg #90 1 qAM
LMOM that Rx's were ready to pick up — Diltiazem 180mg #90 1 qPM
Lanoxin 0.25mg #90 1 qd
Allopurinol 100mg #270 1 tid
RF x 3 GY/AR

10/14/04 See MRI
Left message on cell voice mail re: L5S1 disc protrusion.
Done ICW
Refer to Dr Carr - GY

10/26/04 - Rite Aid - Diltiazem 300mg #30 1 qdm RF x 1 year
Spring Bay — Diltiazem 180mg #30 1 qPM RF x 0 GY/AR

1/28/05 - Pt's wife called said we wrote his Lanoxin Rx wrong when we wrote it. So he needed a new written Rx that had a sig of bid and a qty of #180 - AKoolman RMA
Written Rx - Lanoxin .25mg #180 1 bid RF x 3 GY/AR
LMOM - Rx was ready - AKoolman RMA

2/16/05 - Rite Aid - Lanoxin 0.25mg #20 1 bid (VR) GY/AKoolman RMA
Spring Bay

2-17-05 Rx Previous Sent #90 RF 3

3-9-05 - Caremark - Rx for Prevacid faxed to them / No changes in Rx also GY/AR faxed
Fax

DEMGL:0020

McConnack, Dan

Date 3-17-05
BP 134/82 P 70 R
T Wt 270 Ht
Allergies Sulfa, Septra
Ampacillin
Meds
See Med List

42 y/o → C.C. pt here for o f/u on everything that had been going on. Had been going through a lot of test and wonders if it is time to get another CT. Has been having more abdominal pain lately & has been dealing with the cold and body aches.

- Dan has been the to Stanford twice = ⊕ HLA-B27. Last visit was in December.
- Probably not Ankylosing Spondylitis / Reiters
- He continues to intermittent lower abd pains.
- UTI x 3 in past few weeks & fever
- Gout under good control

O: Heart & nodes consistent (chronic AFib)
Lungs clear Abd benign
Reviewed old scans

A: Abdominal adenopathy / Gout / ⊕ HLA B27
Viral URI / Chronic AFib / Arthralgias

P: CMP, uric acid, lipids, CBC
ABD CT for adenopathy - JR

DEMGL:0019

McCornack, Dan

Date 8-18-05
(D) BP 122/78 P ___ R ___
T ___ Wt 218 Ht ___
Allergies Sulfa, Septra
Ampacillin
Meds
See Med list
Advil prn

42y/o c.c. pt here for pain in his neck, (R) shoulder blade, shoulder, then his (R) arm became numb. Pt says the severe pain is gone, until he lays down or sits a certain way. Pt says his shoulder aches almost all the time. Needs mail away Rx's for all his meds —

Severe pain about 3½ wks ago. Pain started in (R) shoulder blade, radiated to neck, then down (R) arm.
Some relief c chiropractic treatment.
Cervical radiculitis down (R) arm into fingers 3-4-5.
Acute pain in neck is a little better, but arm is worse

O: Mild limitation neck ROM
Sensory: numbness intermittent in C6-C7-C8 distribution
Motor intact in both arms
XRAY C6-7 DDD 1yr ago

A: Cervical radiculitis (R)
Probably C7 nerve root

P: MRI - C Spine
Spine Specialist Referral
Rx all meds with Rx's —

MRI - T.C. 8-16-05 8:00

8-18-05 PC Kathy - Disc protrusion C56
Referring to Spine specialist

Notes faxed to Dr Carr - ab

1/21/05 - Rite Aid - Allopurinol 300mg #20 1 tab QD Rodman
Spring fax

DEMGL:0018

– McCormack, Dan –

11/6/06 – Caremark – Reg Prevacid Sol to Prevacid Solutab GI/AS
fax

DEMGL:0017

– McCormack, Dan –

11/23/05 – Pt needs a 2wk supply of his meds, until his mail order comes in –
Rite Aid – Diltiazem CD 300mg #15 i q AM }
Springfax Diltiazem CD 180mg #15 i q pm } [illegible]
Lanoxin 0.25mg #30 i bid }

Date 7/23/06
BP 118/72 P ___ R ___
T ___ Wt 226 Ht ___
Allergies Sulfa, Septra, Ampicillin
Meds ___

43 y/o ♂ c.c. pt here for his annual physical and annual lab results. Also having a lot of trouble with his back again, so he wants to discuss that. Has also been having trouble with swelling in his ankles on and off. No pain when they are swollen. Started in June. Says he has noticed that he gets up more at night to urinate. Doesn't know if its age related.

PMH - Afib
- gout
- DDD C-spine/L spine
⊕ HLA-B27
Abd adenopathy - chronic/stable
renal stone
GERD

SH - Smoke ∅ EtOH rare
FH - Father colon polyps - precancerous

Had back adjustments c Dr Nicklas c some relief. LBS, pain + can't sleep. Previously saw Dr Carr. Some radiation down ® buttock + tingling into ® foot - Considered epidural steroids - Twisted it playing golf

O: NAD HEENT - WNL Cor RRR s m lungs clear Abd benign
Small umbilical hernia Ext WNL Rectal ok Prostate ok
[illegible] Heme neg

A PE/ Hx AFib/Gout/DDD C+L spine - now c some ® leg radiculitis

P: Referral for colonoscopy Refer to Dr Carr
CMP, lipids, PSA, UA, H/H, Digoxin
Rx Vicodin 5mg #40
TRY Indocin for back pain

Notes faxed to Dr Cushing [illegible]

[illegible signature]

LMOM 7/31/06 [illegible]

DEMGL:0016

McCormack, Dan

Date 8-24-06
BP 124/84 P ___ R ___
T ___ Wt 228 Ht ___
Allergies Sulfa, Septra
Ampicillin
Meds See Med List

43y/o ♂ c.c. pt here for a flu on his labs. Pt says the on occassion he gets a cold sweat and his hands get really cold, this happened the day he had his blood drawn. The lab tech was concerned because they had a hard time getting blood.

Pt c/o persistent fatigue. Hx A-fib since early 20's - followed by Dr VanDollen. No eval x 2 yrs.

O - Occas pedal edema - which could be from Ca++ blocker
- Labs show ↑TRIG. Pt has high fat diet & has gained 10 lbs in past year
- See labs
- Cor - Irreg rate 60's
lungs clear

A: Atrial fib - chronic
Fatigue
Hyperlipidemia

P: Dr VanDollen re-evaluation
Ablation ?
Coumadin ?
Discussed low fat diet & wt loss

[illegible]

10/19/06 - Written Rx - Diltiazem CD 310mg #90 i q AM
Diltiazem CD 180mg #90 i q PM
Lanoxin 0.25mg #180 i bid
allopurinol 100mg #270 iii q day
Prevacid 30mg #90 i q a
} RF x 3 [illegible]

pt will pick up Rx

DEMGL:0015

4414257

— McCornack, Dan —

2/6/07 - CareMark - Prevacid Sol Tab 30mg #90 ī gd RF x3 GW/Ag
fax

Date 3/2/07
Ⓛ BP 130/84 P 84 R
T ___ Wt 225 lbs Ht ___
Allergies Sulfa, Septra
Ampicillin
Meds
See med list

44 y/o ♂ c.c. pt here b/c last pm, he started feeling sharp pains under his Ⓛ arm pit, then went down his Ⓛ arm, under Ⓛ shoulder blade, Ⓛ hand went numb, still a little numb this am, denies SOB, chest pain. most of the time he doesn't feel good. still having some pain in his Ⓛ chest. sees Dr. VonDollen.

S. - Afib - see Von Dollen
Ø diaphoresis Ø chest pressure ī pain yd
Smthly Ⓛ arm
10 yrs ago Ⓝ Stress test.
- Some Back upper spasms last few days
Ø weakness /numbness

PMH - Afib
GERD
Gout.
HLA B27 ⊕
? Ankylosing spond
PSH tonsils
knee surg
FH: CAD 70' grandpa

O/E : Genl: NAD, mod obese.
Lu : RRR, Ø m
Lungs clear
Abd: soft NT
~~Ext: ⊕ Tinel / Phalen~~
~~Bilat~~
Ⓛ arm shoulder
Ⓝ Rom NT
Ⓛ upper ext
Ⓝ Sens
Reflexes

EKG
Afib
NO Δ, except voltage ↓
from 2/04

Ⓐ ① Afib - cont Coumadin
② CP - unlikely cardiac since pt has ⊖ trop, CPK
③ upper Back strain ī slight cervical Radiculopathy
done Stat ✓
F/u ī Dr Lemm pm

DEMGL:0014

McCornack, Dan

Date 4-30-07
DOB 3/3/88 P ____ R ____
T ____ Wt 227 Ht ____
Allergies Sulfa; Septra
Ampicillin
Meds
See Med List

4/4/10 c.c. has burning in his mouth has a spot of concern Quit chewing tabacco about 2 months ago and then he was ago the burning started. Thinks its time for his annual labs and just review his last visit. AS

- Colonoscopy in Jan - one small polyp.
- noticed possible white spot inside ⓛ upper lip this am.
- Also burning sensation in jaw at times, bilaterally - Hx TMJ
- Mother recently started ☆ psoriasis. He is HLA-B27 ⊕ and has extensive rash on knuckles for years.
- also discussed work stress + his possible depression symptoms. Some lack of motivation + loss of interest in fun activities

O: 2 mm raised red spot on mucosa ⓛ upper lip
Affect + insight normal
See labs

A: ORAL LESION; High lipids; Stress reaction

P: ENT referral
RTC ☆ labs = Dig. CMP, lipids, uric acid, TSH

Ref to Dr Murton. ab

DEMGL:0013

McCornack, Dan

Date 6-4-07
BP 132/72 P R
T Wt Ht
Allergies Sulfa, Septra
Ampacillin
Meds
See med list

44 y/o ♂ c.c. 1 month flu and labs
results. Saw Dr. Bukacher SKG
and was not impressed with him
Has an appt ☆ Redwood City to discuss AS
an ablassion done.

Dr Winkle @ Redwood for possible ablation, June 25th for his chronic atrial fib. Oral lesion still "feels funny" at times. He may recheck ☆ Dr. Buckalew.
⊕ HLA B27. Mother ☆ psoriasis. He would like to see Rheumatology

D See labs uric acid 8.0 Chol 262 HDL 36 TRIG 620
Con occas irreg
lungs clear

A: Gout / Hyperlipidemia / chronic A fib

P's Lipids, uric acid 3 mths
Low fat, low purine diet -
We discussed med options -

DEMGL:0012

McConnack, Dan

Date 9-6-07
(L) BP 112/72 P R
T Wt 199 Ht
Allergies Sulfa
Septra, Ampicillin
Meds
Premed List

44/y/o ♂ c.c. 3 month flu and, labs results. Needs new Rx's for mail away. Wants to discuss his visit with Dr Butkachevsky. He continues with pain and a metalic taste in his mouth. Numbness AS and tingling in gums.

He has been on a strict diet and wants to avoid statin. Gout has been under fairly good control. He likes beer and realizes it may contribute to gout.
Intermittent small lesions on (L) upper lip. BCC hx no oral cancer. He has a hx of cold sores.

O: See Labs 8/31/07

HEENT - (L) upper lip just inside mouth - 2 1mm vesicles
No leukoplakia
Cor RRR no murmurs Abd benign Extrem

A: Herpes Simplex I - cold sore, chronic
Hyperlipidemia / Gout / Hx HTN

P: Cont diet / meds
Lipids, uric acid in Jan rept
Rx Lovastatin

9-6-07 Written Rx's - Diltiazem CD 300mg 8 am #90
Diltiazem CD 180mg 8 pm #90
Lanoxin 0.25mg T bid #180
Allopurinol 100mg #270 1 1/2 qd
Premeid 30mg #90 1 po qd
RFx3 GL AS

11/16/07 - Caremark - Prevacid 30mg #90 1 daily RFx3 MB/gs

DEMGL.0011

McCORMACK, DAN

Date 12/5/07
BP 124/78 P R
T Wt 234 Ht
Allergies Sulfa, Ampicillin
Septra
Meds
See med list

44 y/o ♂ C.C. eye irritation, redness, in the Ⓐ eye there looks like there is a lesion near the iris of his eye. Eye site is fine. Eyes do burn a little AS

O: Small pterygium OD c mild scleral injection
No encroachment on iris
Ant chamber clear

A: Pterygium

P: Eye protection
Refresh drops — ½

DEMGL:0010